NIH Clinical

CLINICAL AND PHARMACY MSO - INFUSION - CLINICAL TRIALS

PRIOR AUTHORIZATION REQUEST

Instructions: Please complete this form in its entirety to initiate a prior authorization on behalf of our mutual patient. Once completed, please fax this form and supporting documentation to 515-518-6704. For questions, call 515-518-6654 our team is here to help.

Urgent Request: Is the provider requesting an urgent review? Yes ☐ No ☐

*For this purpose, urgent is defined as when the provider believes that if the request were to take the standard review window period (up to 3 business days) awaiting a final decision that it could put the patient's life, health, or ability to regain function in jeopardy

Type of Request: ☐ New Therapy ☐ Renewal ☐ Pharmacy Billing ☐ Medical Billing

Patient Information

First Name:_____ Last Name:_____ MI:_____ Phone Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Male: ☐ Female: ☐ Check Unit of Measure: Allergies:_____

Height:____in ☐ / ☐ cm Weight:____lb ☐ / ☐ Kg

Patient's Authorized Representative: _____ Authorized Representative Phone Number: _____

Primary Insurance Name:_____ Primary Insurance ID Number:_____

Secondary Insurance Name:_____ Secondary Insurance ID Number:_____

Prescriber Information

First Name:_____ Last Name:_____ Specialty:_____

Fax Number:_____ Address:_____ City:_____

State:_____ Zip Code:_____ Phone Number:_____ Email Address:_____

Requester (If different than prescriber): _____ Office Contact Person:_____

NPI Number (Individual):_____ DEA Number (If required):_____

Medication/Medical Dispensing Information

Medication Name:_____ Dosage/ Strength:_____ Frequency:_____

Length of Therapy:_____ # of Refills:_____ Quantity: (per 30 days) _____ JCODE:_____

Route of Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Inhalation ☐ Device ☐ Other_____

Administration Location: ☐ Patient's Home/ Self- Adminstered ☐ Physician's Office ☐ Ambulatory Infusion Center ☐ Patient's Home/ Homecare Administered ☐ Outpatient Hospital Care ☐ Other_____

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Patient Name:_____ **Primary Insurance ID Number:**_____

New Therapy Clinical Information

Previous Therapy: (Specify Drug Name and Dosage):	**Duration of Previous Therapy:** (Specify Dates):	**Response/Reason for Failure/ Allergy:**

List Diagnose:	**ICD-10 Codes:**

Required Clinical Information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates, and/or justification for initial or ongoing therapy or increased Current Medication List dose, and if the patient has any contraindications for the health plan/ insurer preferred drug. Laboratory results with dates are required if needed to establish diagnosis orevaluate response. Please provide any additional clinical information or comments pertinent to this requires for coverage (eg., formulary tier exceptions.)

☐ **Check if Attachments**
(Please see attached):

Current Medication List

Complete For Renewal Therapy

Date Therapy Initiated:_____Duration of Therapy (Specific dates) _____

Response to Therapy:_____

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or is designee may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature_____ **Date:**_____